		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 48868

Facility Name: Heritage Manor Chillicothe, LLC

Address: 1028 HILLCREST DRIVE (Number) Chillicothe (City) 61523 (Zip Code)

County: Peoria

Telephone Number: (309) 274-2194 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: July 2007

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		x	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Ater **Telephone Number:** (309) 823-7135
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Craig Ater
(Title) Exec VP & CFO

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	110	Skilled (SNF)	110	40,150	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,150	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,288	8,623	3,751	36,662	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,288	8,623	3,751	36,662	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.31%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started July 2007

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date July 2007 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified _____ and days of care provided 3,751

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	235,851	17,948		253,799		253,799	6,171	259,970			1
2	Food Purchase		245,256		245,256		245,256	21	245,277			2
3	Housekeeping	113,832	24,895		138,727		138,727	9	138,736			3
4	Laundry	38,308	9,993		48,301		48,301	6	48,307			4
5	Heat and Other Utilities			97,954	97,954		97,954	2,174	100,128			5
6	Maintenance	57,797	71,438	52,378	181,613		181,613	15,997	197,610			6
7	Other (specify):*											7
8	**TOTAL General Services**	445,788	369,530	150,332	965,650		965,650	24,378	990,028			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000	89	12,089			9
10	Nursing and Medical Records	1,887,578	151,983	8,621	2,048,182		2,048,182		2,048,182			10
10a	Therapy		337,086	651,583	988,669	(361,787)	626,882	200,304	827,186			10a
11	Activities	63,233	7,812		71,045		71,045		71,045			11
12	Social Services	24,280		3,455	27,735		27,735		27,735			12
13	CNA Training	1,318	832		2,150		2,150	885	3,035			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,976,409	497,713	675,659	3,149,781	(361,787)	2,787,994	201,278	2,989,272			16
	C. General Administration											
17	Administrative	69,160			69,160		69,160	93,913	163,073			17
18	Directors Fees											18
19	Professional Services			291,163	291,163		291,163	(279,937)	11,226			19
20	Dues, Fees, Subscriptions & Promotions			171,399	171,399	(60,225)	111,174	(67,413)	43,761			20
21	Clerical & General Office Expenses	187,723	23,927	13,078	224,728		224,728	207,209	431,937			21
22	Employee Benefits & Payroll Taxes			565,141	565,141		565,141	43,569	608,710			22
23	Inservice Training & Education			326	326		326	541	867			23
24	Travel and Seminar			13,782	13,782		13,782	(11,783)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			51,975	51,975		51,975	12,768	64,743			26
27	Other (specify):*			490	490		490	(240)	250			27
28	**TOTAL General Administration**	256,883	23,927	1,107,354	1,388,164	(60,225)	1,327,939	(1,373)	1,326,566			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,679,080	891,170	1,933,345	5,503,595	(422,012)	5,081,583	224,283	5,305,866			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heritage Manor Chillicothe, LLC #48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							253,707	253,707			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,724	10,724		10,724	222,021	232,745			32
33	Real Estate Taxes							73,085	73,085			33
34	Rent-Facility & Grounds			481,800	481,800		481,800	(480,751)	1,049			34
35	Rent-Equipment & Vehicles			6,558	6,558		6,558	1,024	7,582			35
36	Other (specify):*											36
37	**TOTAL Ownership**			499,082	499,082		499,082	69,086	568,168			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					361,787	361,787		361,787			39
40	Barber and Beauty Shops			6,472	6,472		6,472		6,472			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					60,225	60,225		60,225			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			6,472	6,472	422,012	428,484		428,484			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,679,080	891,170	2,438,899	6,009,149		6,009,149	293,369	6,302,518			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(6,068)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		23		16
17	Non-Care Related Fees	(3,384)	20		17
18	Fines and Penalties				18
19	Entertainment	(22,221)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,171)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(240)	27		24
25	Fund Raising, Advertising and Promotional	(70,113)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (111,197)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	404,566		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 404,566		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 293,369		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Heritage Manor Chillicothe, LLC

ID# 48868

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(3,384)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(9,171)	19	22
23				23
24		(240)	27	24
25		(70,113)	20	25
26				26
27				27
28				28
29			33	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(82,908)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	6,171	0	0	0	0	0	0	0	0	6,171	1
2	Food Purchase	0	0	21	0	0	0	0	0	0	0	0	21	2
3	Housekeeping	0	0	9	0	0	0	0	0	0	0	0	9	3
4	Laundry	0	0	6	0	0	0	0	0	0	0	0	6	4
5	Heat and Other Utilities	0	0	2,174	0	0	0	0	0	0	0	0	2,174	5
6	Maintenance	0	0	15,997	0	0	0	0	0	0	0	0	15,997	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	24,378	0	0	0	0	0	0	0	0	24,378	8
	B. Health Care and Programs													
9	Medical Director	0	0	89	0	0	0	0	0	0	0	0	89	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	200,304	0	0	0	0	0	0	0	0	0	200,304	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	885	0	0	0	0	0	0	0	0	885	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	200,304	974	0	0	0	0	0	0	0	0	201,278	16
	C. General Administration													
17	Administrative	0	0	93,913	0	0	0	0	0	0	0	0	93,913	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,171)	(281,992)	11,226	0	0	0	0	0	0	0	0	(279,937)	19
20	Fees, Subscriptions & Promotions	(73,497)	0	6,084	0	0	0	0	0	0	0	0	(67,413)	20
21	Clerical & General Office Expenses	0	0	207,209	0	0	0	0	0	0	0	0	207,209	21
22	Employee Benefits & Payroll Taxes	0	0	43,569	0	0	0	0	0	0	0	0	43,569	22
23	Inservice Training & Education	0	0	541	0	0	0	0	0	0	0	0	541	23
24	Travel and Seminar	(22,221)	0	10,438	0	0	0	0	0	0	0	0	(11,783)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	12,768	0	0	0	0	0	0	0	0	12,768	26
27	Other (specify):*	(240)	0	0	0	0	0	0	0	0	0	0	(240)	27
28	**TOTAL General Administration**	(105,129)	(281,992)	385,748	0	0	0	0	0	0	0	0	(1,373)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(105,129)	(81,688)	411,100	0	0	0	0	0	0	0	0	224,283	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	240,746	0	12,961	0	0	0	0	0	0	0	253,707	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,068)	227,425	0	664	0	0	0	0	0	0	0	222,021	32
33	Real Estate Taxes	0	73,085	0	0	0	0	0	0	0	0	0	73,085	33
34	Rent-Facility & Grounds	0	(481,800)	0	1,049	0	0	0	0	0	0	0	(480,751)	34
35	Rent-Equipment & Vehicles	0	0	0	1,024	0	0	0	0	0	0	0	1,024	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,068)	59,456	0	15,698	0	0	0	0	0	0	0	69,086	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(111,197)	(22,232)	411,100	15,698	0	0	0	0	0	0	0	293,369	45

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Heritage Enterprises, Inc.	100	See Page 25				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	200,304	200,304	2
3	V								3
4	V	19	Adjustment for Related Organization	281,992	Heritage Operations Group, LLC	0.00%		(281,992)	4
5	V								5
6	V	34	Adjustment for Related Organization	481,800	Heritage Manor Real Estate, LLC	0.00%		(481,800)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		73,085	73,085	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		222,890	222,890	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		240,746	240,746	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		4,535	4,535	10
11	V								11
12	V								12
13	V								13
14	Total			$ 763,792			$ 741,560	$ * (22,232)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.		$	$ 6,171	15
16	V	2	Food Purchase					21	16
17	V	3	Housekeeping					9	17
18	V	4	Laundry					6	18
19	V	5	Heat & Other Utilities					2,174	19
20	V	6	Maintenance					15,997	20
21	V	7	Other					0	21
22	V	9	Medical Director					89	22
23	V	10	Nursing & Medical Records					0	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					885	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					93,913	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					11,226	31
32	V	20	Fees, Subscription, Promotions					6,084	32
33	V	21	Clerical & General Office Expenses					207,209	33
34	V	22	Employee Benefits & Payroll Taxes					43,569	34
35	V	23	Inservice Training & Education					541	35
36	V	24	Travel and Seminar					10,438	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					12,768	38
39	Total			$			$ 0	$ * 411,100	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Enterprises, Inc.		$	$ 0	15
16	V	30	Depreciation					12,961	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					664	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					1,049	20
21	V	35	Rent-Equipment & Vehicles					1,024	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 15,698	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.	Member		100.00					$ 0		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Heritage Operations Group
Street Address: box 3188
City / State / Zip Code: Bloomington, Il 61701
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,735	26	$ 153,442	$ 153,115	110	$ 6,171	1
2	2	Food Purchase	Beds	2,735	26	520	0	110	21	2
3	3	Housekeeping	Beds	2,735	26	215	0	110	9	3
4	4	Laundry	Beds	2,735	26	151	0	110	6	4
5	5	Heat & Other Utilities	Beds	2,735	26	54,054	0	110	2,174	5
6	6	Maintenance	Beds	2,735	26	397,756	75,127	110	15,997	6
7	7	Other	Beds	2,735	26	0	0	110	0	7
8	9	Medical Director	Beds	2,735	26	2,206	0	110	89	8
9	10	Nursing & Medical Records	Beds	2,735	26	0	0	110	0	9
10	11	Activities	Beds	2,735	26	0	0	110	0	10
11	12	Social Service	Beds	2,735	26	0	0	110	0	11
12	13	Nurse Aide Training	Beds	2,735	26	22,009	20,793	110	885	12
13	14	Program Transportation	Beds	2,735	26	0	0	110	0	13
14	15	Other	Beds	2,735	26	0	0	110	0	14
15	17	Administrative	Beds	2,735	26	2,335,023	2,335,023	110	93,913	15
16	18	Directors Fees	Beds	2,735	26	0	0	110	0	16
17	19	Professional Services	Beds	2,735	26	279,109	0	110	11,226	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	151,258	0	110	6,084	18
19	21	Clerical & General Office Expens	Beds	2,735	26	5,151,979	4,517,846	110	207,209	19
20	22	Employee Benefits & Payroll Tax	Beds	2,735	26	1,083,278	0	110	43,569	20
21	23	Inservice Training & Education	Beds	2,735	26	13,460	0	110	541	21
22	24	Travel and Seminar	Beds	2,735	26	259,533	0	110	10,438	22
23	25	Other Admin. Staff Transportatio	Beds	2,735	26	0	0	110	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,735	26	317,454	0	110	12,768	24
25	TOTALS					$ 10,221,447	$ 7,101,904		$ 411,100	25

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Heritage Operations Group
Street Address: box 3188
City / State / Zip Code: Bloomington, Il 61701
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,735	26	$	$	110	$	1
2	30	Depreciation	Beds	2,735	26	322,258		110	12,961	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			110		3
4	32	Interest	Beds	2,735	26	16,517		110	664	4
5	33	Real Estate Taxes	Beds	2,735	26			110		5
6	34	Rent-Facility & Grounds	Beds	2,735	26	26,080		110	1,049	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	25,461		110	1,024	7
8	36	Other	Beds	2,735	26			110		8
9	38	Medically Nec Transportation	Beds	2,735	26			110		9
10	39	Ancillary Service Centers	Beds	2,735	26			110		10
11	40	Barber and Beauty Shops	Beds	2,735	26			110		11
12	41	Coffee and Gift Shops	Beds	2,735	26			110		12
13	42	Other	Beds	2,735	26			110		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 390,316	$		$ 15,698	25

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Busey Bank		xx	Mortgage			$	$	03/2016	variable	$ 222,890	1
2	Busey Bank		xx	Loan Fees							4,535	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		xx	Accounts Receivable							10,724	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 238,149	9
	B. Non-Facility Related*											
10	Interest Income										(6,068)	10
11	Allocated Corporate										664	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,404)	14
15	TOTALS (line 9+line14)						$	$			$ 232,745	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 73,085	2
3. Under or (over) accrual (line 2 minus line 1).		$ 73,085	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 73,085	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	42,119	8
	2007	39,581	9
	2008	75,324	10
	2009	79,983	11
	2010	73,085	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor Chillicothe, LLC COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 48868

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	0529376016	nursing home	$ 71,852.00	$ 71,852.00
2.	0529376017		$ 1,198.00	$ 1,198.00
3.	0529380001		$ 35.00	$ 35.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 73,085.00	$ 73,085.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,331 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 129,000	1
2					2
3	TOTALS			$ 129,000	3

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	110				$ 3,301,403	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Awning			1998	2,334						9
10	Heritage Sign			1998	1,860						10
11	Chiller Replacement			1998	54,444						11
12											12
13	Interior Remodel--Materials			1999	154,576						13
14				1999							14
15	Interior Remodel--Professional Fees			1999	24,247						15
16											16
17	Water Heater controls			2000	1,347						17
18	Water Heater			2000	57,254						18
19	Door Locks			2000	1,997						19
20	Heat / Cool Fan			2000	1,598						20
21	Fire Alarm System			2000	4,400						21
22	Alzheimer Unit -- Professional Fees			2000	25,115						22
23	Interior Remodel--Materials (see attached)			2000	93,951						23
24	Interior Remodel--Labor (see attached)			2000	23,130						24
25	Interior Remodel--Professional Fees (see attached)			2000	5,762						25
26											26
27	Water Softener			2001	4,246						27
28	Boiler			2001	29,350						28
29	Door Holders			2001	654						29
30	Alzheimer Unit -- Professional Fees			2001	4,660						30
31											31
32											32
33	C/O Allocation							12,961	12,961		33
34	Book Depreciation					191,584		191,584			34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpet	2002	$ 2,373	$		$	$	$	37
38	Compressor	2002	1,164						38
39	Compressor	2002	7,234						39
40	Windows	2002	1,722						40
41									41
42	Storge Tank	2003	737						42
43	In-sink Aerator	2003	810						43
44	Boiler	2003	16,393						44
45	Carpet	2003	2,839						45
46									46
47	Smoke detectors	2004	2,285						47
48	Dinning Room Waitress	2004	2,617						48
49	Parking Lot Sealcoat	2004	4,926						49
50	Boiler Pipe	2004	3,775						50
51	Auto Trans Switch	2004	16,847						51
52	Day Room	2004	1,778						52
53									53
54	Day Room	2005	8,753						54
55	Boiler	2005	19,619						55
56	Fire Alarm	2005	1,628						56
57	Resident Room Carpet	2005	698						57
58	Security System	2005	6,393						58
59	Breaker Replacement	2005	1,980						59
60	Condenser	2005	1,118						60
61	Roof	2005	188,466						61
62	Wiring	2005	820						62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,087,303	$ 191,584		$ 204,545	$ 12,961	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,087,303	$ 191,584		$ 204,545	$ 12,961	$	1
2	Heat pump	2006	5,669						2
3	Boiler	2006	72,981						3
4	fire Alarm	2006	3,553						4
5	Roof	2006	1,300						5
6	Kitchen remodel	2006	4,623						6
7	Carpet	2006	1,139						7
8	Condensing Unit	2006	2,000						8
9	East Wing Dinning Room Remodel	2006	5,228						9
10									10
11	East Wing Remodel-- paint, floors	2007	23,281						11
12	Boiler	2007							12
13	Fire Alarm	2007							13
14	Generator	2007							14
15	Code Alert	2007	4,622						15
16	Fence	2007	3,089						16
17	Landscapping	2007							17
18	Parking Lot sealer	2007	5,000						18
19	Generator	2007	8,260						19
20	Heat pump	2007	21,969						20
21	Water Line	2007							21
22									22
23	East Wing Remodel-- paint, floors	2008	61,290						23
24	Sprinkler Backflow	2008	4,360						24
25	Heat pump	2008	16,046						25
26	Soiled Utility/Med Room	2008	2,622						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,334,335	$ 191,584		$ 204,545	$ 12,961	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,334,335	$ 191,584		$ 204,545	$ 12,961	$	1
2									2
3	Window replacements	2009	64,129						3
4									4
5	HVAC	2009	6,180						5
6	Heat Pump	2009	26,052						6
7	Nurse Call system	2009	226,889						7
8									8
9	Chiller	2010	3,429						9
10	Data Equipment Relocation	2010	2,658						10
11	Roof	2010	129,751						11
12	Paint, flooring & Labor Dining Room	2010	7,567						12
13									13
14	Sprinkler system	2011	77,240						14
15	Coil Unit	2011	3,744						15
16	Fluid cooler	2011	40,567						16
17	Exhaust fans	2011	7,141						17
18	Concrete walkway	2011	10,067						18
19	Remodel Administror's office	2011	3,200						19
20	Sign	2011	19,723						20
21	Boiler	2011	13,577						21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,976,249	$ 191,584		$ 204,545	$ 12,961	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 702,424	$ 49,162	$ 49,162	$		$	71
72	Current Year Purchases	34,044						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 736,468	$ 49,162	$ 49,162	$		$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,841,717	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 240,746	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 253,707	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,961	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 6,558 Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			832		832
3	Classroom Wages	(a)				
4	Clinical Wages	(b)		1,318		1,318
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$ 2,150	$	$ 2,150
10	SUM OF line 9, col. 1 and 2	(e)	$ 2,150			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 201,210	$		$ 201,210	1
2	Licensed Speech and Language Development Therapist		hrs			154,176			154,176	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			271,333	163		271,496	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				336,923		336,923	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					24,864			24,864	13
14	TOTAL			$		$ 651,583	$ 337,086		$ 988,669	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 75,980	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,002,285		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,785		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(410,576)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 675,474	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 675,474	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 256,918	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	277,606		30
31	Accrued Taxes Payable (excluding real estate taxes)	(756)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 533,768	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 533,768	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 141,706	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 675,474	$	48

*(See instructions.)

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (548,688)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (548,688)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	690,394	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 690,394	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 141,706	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,275,794	1
2	Discounts and Allowances for all Levels	(2,160,793)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,115,001	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,989,405	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,989,405	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,358	12
13	Barber and Beauty Care	7,079	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	578,451	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,591	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 589,479	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,068	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,068	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		(410)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (410)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,699,543	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	965,650	31
32	Health Care	3,149,781	32
33	General Administration	1,388,164	33
	B. Capital Expense		
34	Ownership	499,082	34
	C. Ancillary Expense		
35	Special Cost Centers	6,472	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,009,149	40
41	**Income before Income Taxes (line 30 minus line 40)****	690,394	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 690,394	43

*** This must agree with page 4, line 45, column 4.**

**** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

***** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,653	1,717	$ 53,828	$ 31.35	1
2	Assistant Director of Nursing	2,266	2,318	70,940	30.60	2
3	Registered Nurses	10,743	10,867	298,082	27.43	3
4	Licensed Practical Nurses	17,643	18,162	448,615	24.70	4
5	CNAs & Orderlies	66,025	67,752	923,512	13.63	5
6	CNA Trainees	125	125	1,318	10.54	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,760	5,034	92,601	18.40	8
9	Activity Director					9
10	Activity Assistants	4,895	4,957	63,233	12.76	10
11	Social Service Workers	1,846	1,911	24,280	12.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,606	20,202	235,851	11.67	15
16	Dishwashers					16
17	Maintenance Workers	2,497	2,771	57,797	20.86	17
18	Housekeepers	10,199	10,525	113,832	10.82	18
19	Laundry	3,808	3,918	38,308	9.78	19
20	Administrator	1,900	2,080	69,160	33.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,741	10,250	187,723	18.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,707	162,589	$ 2,679,080 *	$ 16.48	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		12,000		36
37	Medical Records Consultant		1,840		37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,600		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,455		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 23,895		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Wade Cies			$ 69,160
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 69,160

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Mgt	$ 281,992
		0
		0
Legal adj to Zero		9,171
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 291,163

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 73,004
Unemployment Compensation Insurance	29,819
FICA Taxes	204,950
Employee Health Insurance	224,491
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
	0
Other Benefits	32,877
Central Office Allocation	43,569
TOTAL (agree to Schedule V, line 22, col.8)	$ 608,710

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	21,922
Health Care Worker Background Check	
(Indicate # of checks performed)	1,400
Patient Background Checks	
	24,535
Dues & Subscriptions	12,400
License & Fees	5,339
Central Office Allocation	6,084
Less: Public Relations Expense	(24,535)
Non-allowable advertising	(3,384)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,761

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	10,981
	71
Seminar Expense	2,730
Central Office	(11,783)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

**See instructions.

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heritage Manor Chillicothe, LLC # 48868 Report Period Beginning: 01/01/11 Ending: 12/31/11

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Health Care Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **xx** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Heritage Manor Chillicothe 43885 07/2007

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **60,225**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **2,189**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Sulaski & Webb**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees

Related Parties
From Page 6

FACILITY		STATE LICENSE NUMBER
Owned SNFs		
Heritage Health - South, LLC		48843
Heritage Health - Bloomington, LLC		48157
Heritage Health - Carlinville, LLC		48850
Heritage Health - Chillicothe, LLC		48868
Heritage Health - Dwight, LLC		50492
Heritage Health - Elgin, LLC		48132
Heritage Health - El Paso, LLC		48124
Heritage Health - Gibson City, LLC		48116
Heritage Health - Gillespie, LLC		48892
Heritage Health - LaSalle, LLC		51276
Heritage Health - Litchfield, LLC		48900
Heritage Health - Mendota, LLC		48108
Heritage Health - Minonk, LLC		48058
Heritage Health - Mt. Sterling, LLC		48041
Heritage Health - Mt. Zion, LLC		48074
Heritage Health - Normal, LLC		48082
Heritage Health - Pana, LLC		48884
Heritage Health - Peru, LLC		48090
Heritage Health - Staunton, LLC		48876
Heritage Health - Streator, LLC		48066
Barton W. Stone Jacksonville, LLC		48918
Danville Joint Ventures, LLC d/b/aColonial Manor		42168
Heritage Health - Springfield		41699
Cotillion Ridge		45138
Country Health		7880
Mason City Area NH		34256
St. Clara's Manor		50724
Vonderlieth Living Center		19976